CoverKids

What is CoverKids?

CoverKids is full health coverage for children and pregnant women who cannot afford employer sponsored insurance or individual insurance and who make too much to be eligible for TennCare. CoverKids provides free medical and vision benefits. Preventive healthcare is free! Sick visits and medication have very low co-pays.

Children can get this coverage if:

- They are under the 19 years of age on the date of application.
- They are Tennessee residents.
- They have no other health insurance and have not had coverage in the last three months.
- They do not have access to state-sponsored health insurance.
- They are not eligible for or enrolled in TennCare. This is not TennCare. Applications are first reviewed for possible TennCare eligibility. If it appears that a child may be eligible for TennCare, the applicant will be asked to complete a TennCare application. Families can receive help to complete the TennCare application.
- They are citizens of the United States or qualified aliens. Examples of documents to prove qualified alien status include: Form I-551 or Form I-94.

Pregnant women can get this coverage if:

- They have no other health insurance that included maternity benefits and have not had coverage with maternity benefits in the last three months.
- They are Tennessee residents.
- They do not have access to state-sponsored health insurance.
- They are not eligible or enrolled in TennCare.
- They are at or below 250% of the Federal Poverty Level (FPL).

If your family falls **under** a certain income guideline (under 250% of the FPL) and eligibility requirements are met, **there are no monthly premium payments.**

Number of People in Family	250% of the FPL
1	$26,000
2	$35,000
3	$44,000
4	$53,000
5	$62,000
6	$71,000
7	$80,000
8	$89,000

Your family can still apply for children **over 250% of the FPL,** but full premiums must be paid every month for each child **over 250% of the FPL.**

If your application is complete, your family should receive notification within 10 business days that your application was received and is being processed for eligibility.

Need help?

- If you are a person with a hearing or speech disability and need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known by calling **1-866-620-8864 • TTY 1-866-447-0272 • (FAX 1-866-913-1046)**

- If you have any questions or need help completing this form, please call CoverKids at **1-866-620-8864** (this is a free call). The hours are Monday through Friday, 7 a.m. to 6 p.m. (Central Standard Time).

- Language interpreter services are available at no cost.

Amharic **አማርኛ**

ይህንን ማመልከቻ ለመሙላት እርዳታ ካስፈለጎት በዚህ ስልክ ይደውሉልን 1-866-579-4156 **ወይም** (615) 313-9975 **ናሽቪል ።። በተጨማሪም የትርጉም አገልግሎት በተለያዩ ቋንቋዎች ፥ እንዲሁም በአማርኛ እንሰጣለን ።። ይደውሉልን አገልግሎታችን ነጻ ነው ።።**

Arabic **العـــربيـــة**

إذا كنت تحتاج الى مساعدة لفهم هذه الاستمارة أو اية رسائل بخصوص كوفر كدز (CoverKids) **بالعـــربيـــة، رجاءً اتصـــــل بـــــ 313-9906 من داخـــل ناشـــفل أو بـــ 1-866-626-3411 من خارج ناشفل. هذه المكالمة مجانية.**

Bosnian **Bosanski**

Ako vam treba pomoć u razumjevanju ove molbe ili bilo kojeg CoverKids pisma na Bosanskom/Srpskom/Hrvatskom molimo zovite 313-9382 ili 1-877-652-3069 izvan Nashville. Ovaj poziv se ne plaća.

French **Français**

Si vous avez besoin de l'aide avec la demande, appellons-nous à 1-866-579-4241 ou (615) 244-0479 à Nashville. L'appel est gratuit. Les services de l'interprétation de langues sont disponible dans beaucoup de langues, y compris le français.

Kurdish - Badinani **كوردى – بادينانى**

ئەگەر تو پێتڤی هاریکاریێ بی بو تێگەهشتنا ڤی فۆرمێ یان هـەر نامـەکی دەربـارەی (کەڤـەر کیـدن) (CoverKids) **بـــ کـــوردی، پـەیـوەنـدیـێ بـکە بـــ 313 – 9906 لـــ ناشـــڤل یـان بـــ 1–866–626–3413 لـــ دەرڤەی ناشڤل. ئەڤ تەلەفۆنە خۆڕاییە.**

Russian **Русский**

Если Вам необходима помощь в заполнении формы, звоните нам по бесплатному номеру 1-866-579-4243 или по местному (615) 244-0472. Мы говорим на многих языках включая русский.

Somali **Soomaali**

Hadii aad rabtid inaad ku fahamtid af Soomaali waraaqahan CoverKids, fadlan la xidhiidh (615) 313-9894 Nashville gudaheeda, dibadeedana 1-877-652-3054 oo bilaash ah.

Spanish **Español**

Si Ud. necesita ayuda con la aplicación, llámenos al 1-866-626-3409. La llamada es gratis. Los servicios del intérprete del idioma están disponibles en muchos idiomas incluyendo Español.

Vietnamese **Tiếng Việt**

Nếu quý vị cần giúp đỡ để hiểu thêm chi tiết về lá đơn hoặc lá thư về chương trình của CoverKids bằng Việt Ngữ, thì xin gọi số (615) 313-9899 trong vùng Nashville, hoặc gọi số miễn phí 1-800-269-4901.

Section 1 - Responsible Adult Information

(Person to whom correspondence should be sent.) List only people currently living in the household.

1st Responsible Adult/Parent/Guardian Living in Household

Name First | M.I. | Last

Suffix (III, IV, Jr., Sr.) | Date of Birth MM / DD / YYYY | Sex ☐ Male ☐ Female | * Social Security #

Are you pregnant? ☐ Yes ☐ No

Are you applying for maternity benefits for yourself? ☐ Yes ☐ No (If Yes, you must fill out Section 3)

Street Address
Number and street, including apartment number

City | State | ZIP Code | County

Mailing Address
(If different from Street Address)
Number and street, including apartment number

City | State | ZIP Code | County

Phone Numbers Home | Work | Cell

What is your family's preferred language ☐ English ☐ Spanish ☐ Other_____

Employer Name
(Tell us if you are self-employed)

Are you a state government or local education worker? ☐ Yes ☐ No

2nd Responsible Adult/Parent/Guardian Living in Household

Name First | M.I. | Last

Suffix (III, IV, Jr., Sr.) | Date of Birth MM / DD / YYYY | Sex ☐ Male ☐ Female | * Social Security #

Are you pregnant? ☐ Yes ☐ No

Are you applying for maternity benefits for yourself? ☐ Yes ☐ No (If Yes, you must fill out Section 3)

Phone Numbers Home | Work | Cell

Employer Name
(Tell us if you are self-employed)

Are you a state government or local education worker? ☐ Yes ☐ No

*Requested but optional for responsible adults.

Section 2 - Child Information. List all children under 19 years old in your home. (If there are more than 4 children in household for whom you wish to apply, please attach a separate sheet.) The name of the child(ren) should be same as it appears on the child(ren)'s birth certificate.

List below all of the children who live with you by filling in the spaces below. *You must provide the Social Security Number for each child for which you are applying. (If there are more than 4 children in your household, please fill out another copy of this page for the additional children.)	Citizenship & Race/Ethnicity	Does this child have health insurance other than TennCare? (If Yes, copy the front and back of each insurance card and send it with your application.)	Does this child have or has had TennCare Medicaid/ TennCare Standard?
CHILD 1 Name First / M.I. / Last Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No Are you applying for Maternity Benefits for this child? ☐ Yes ☐ No (If Yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	Is this child a U.S. Citizen? ☐ Yes ☐ No (If No, you must send a document that tells this child's legal status with your application.) Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:** Has this child had health insurance in the last 3 months? ☐ Yes ☐ No **If yes, Name of Insurance:** **Date Insurance Ended:** MM / DD / YYYY	☐ Yes ☐ No **If yes, which one?** ☐ TennCare Medicaid ☐ TennCare Standard **Date TennCare Ended:** MM / DD / YYYY **Have you filed an appeal?** ☐ Yes ☐ No
CHILD 2 Name First / M.I. / Last Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No Are you applying for Maternity Benefits for this child? ☐ Yes ☐ No (If Yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	Is this child a U.S. Citizen? ☐ Yes ☐ No (If No, you must send a document that tells this child's legal status with your application.) Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:** Has this child had health insurance in the last 3 months? ☐ Yes ☐ No **If yes, Name of Insurance:** **Date Insurance Ended:** MM / DD / YYYY	☐ Yes ☐ No **If yes, which one?** ☐ TennCare Medicaid ☐ TennCare Standard **Date TennCare Ended:** MM / DD / YYYY **Have you filed an appeal?** ☐ Yes ☐ No
CHILD 3 Name First / M.I. / Last Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No Are you applying for Maternity Benefits for this child? ☐ Yes ☐ No (If Yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	Is this child a U.S. Citizen? ☐ Yes ☐ No (If No, you must send a document that tells this child's legal status with your application.) Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:** Has this child had health insurance in the last 3 months? ☐ Yes ☐ No **If yes, Name of Insurance:** **Date Insurance Ended:** MM / DD / YYYY	☐ Yes ☐ No **If yes, which one?** ☐ TennCare Medicaid ☐ TennCare Standard **Date TennCare Ended:** MM / DD / YYYY **Have you filed an appeal?** ☐ Yes ☐ No
CHILD 4 Name First / M.I. / Last Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No Are you applying for Maternity Benefits for this child? ☐ Yes ☐ No (If Yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	Is this child a U.S. Citizen? ☐ Yes ☐ No (If No, you must send a document that tells this child's legal status with your application.) Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:** Has this child had health insurance in the last 3 months? ☐ Yes ☐ No **If yes, Name of Insurance:** **Date Insurance Ended:** MM / DD / YYYY	☐ Yes ☐ No **If yes, which one?** ☐ TennCare Medicaid ☐ TennCare Standard **Date TennCare Ended:** MM / DD / YYYY **Have you filed an appeal?** ☐ Yes ☐ No

Section 3 - Information About Pregnancy

Fill out this section ONLY if you are applying for maternity benefits for a pregnant adult or child. Do NOT fill out if you are not pregnant. Go to Section 4. You must have your doctor send a letter stating you are pregnant, how many babies you are carrying, and the due date.

Name of person applying for maternity benefits:

First _____ M.I. _____ Last _____

Are you a U.S. Citizen? ☐ Yes ☐ No (Babies born in the U.S. will be considered U.S. citizens)

What is the due date? ☐☐ / ☐☐ / ☐☐☐☐ (MM / DD / YYYY) How many babies are you carrying? ☐

Do you have health insurance? ☐ Yes ☐ No

If Yes, Name of Insurance Company_____

(Copy the front and back of each insurance card and send it with your application. Also send a copy of the confirmation letter if coverage was involuntarily lost.)

Does your health insurance include maternity benefits (prenatal and delivery care)? ☐ Yes ☐ No

Have you had health insurance that ended in the past 3 months? ☐ Yes ☐ No

(If Yes, a written statement must be sent with your application, listing the policy number and insurance company name with an explanation of why the insurance ended.)

If Yes, Name of Insurance Company_____

(Copy the front and back of each insurance card and send it with your application.)

Date insurance ended: ☐☐ / ☐☐ / ☐☐☐☐ (MM / DD / YYYY)

Do you have CoverTN Insurance? ☐ Yes ☐ No

Are you or have you been enrolled in TennCare Medicaid or TennCare Standard? ☐ Yes ☐ No

If Yes, which one? ☐ TennCare Medicaid ☐ TennCare Standard When did it end? ☐☐ / ☐☐ / ☐☐☐☐ (MM / DD / YYYY)

Your doctor can fill out the provider's statement found at this internet address:
http://www.covertn.gov/web/coverkids_app_english_provider.pdf

Section 4 - Gross Household Income (Please list **everyone living in the household** who receives income and the source of the income**):** Please add together monthly income amounts from each job if you have more than one job.

Income may be any of the following:

1. Wages/Pay
2. Self-Employment Income
3. Unemployment Benefits
4. Worker's Compensation
5. Military Allotment
6. Veteran's Benefits
7. Retirement Benefits
8. Interest Income
9. Families First
10. Strike Benefits
11. Investment Income
12. Cash from Friends/Family
13. Supplemental Security Income (SSI)
14. Retirement Survivors Disability Insurance (RSDI)
15. Rental Income paid **to** you
16. Social Security Benefits
17. Other (Please specify): _____

Name of Person receiving Source of Income	**Income Type** (fill in number from list above)	**Gross Monthly Amount (Before Taxes)**	**If Self-Employed, Monthly Allowable Federal Tax Deductions** Such as estimated tax, which includes tax you pay to the Federal government and self-employment taxes.

Section 5 - Child Support and Daycare

List below if you **are paying** child support for a child **not** living with you and indicate the monthly amount you pay.

Child's Name (First and Last Name)	**Monthly Amount PAID** (Child **NOT** living with you)
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑

We want to know about the child(ren) living with you. Please tell us if you pay daycare expenses (yes or no) and if you receive child support for the child(ren) listed (please tell us the amount).

Child's Name (First and Last Name)	**Daycare**	**Monthly Child Support Amount Received** (Child living **WITH** you)
	☐ Yes ☐ No	$_____
	☐ Yes ☐ No	$_____
	☐ Yes ☐ No	$_____

Section 6 - Certification, Understanding, and Authorization

◆ I understand that signing this authorization is required for enrollment in this health plan.

◆ I understand that if I get more benefits than I am entitled to through my fault, I may have to repay any extra benefits.

◆ Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, or national origin. If you have a complaint regarding discrimination, please call 1-800-253-9981 or 615-741-4517.

◆ I understand that enrollment in CoverKids will be continuous for 12 months unless any of the following occur: The child turns age 19; the child or pregnant woman gains access to state-sponsored health insurance through a family member's or their own employment with a public agency; the CoverKids beneficiary is enrolled into individual or group coverage; 60 days after the pregnancy ends for a woman enrolled because of pregnancy; the family fails to pay CoverKids premiums; an audit or periodic review indicates that a CoverKids beneficiary is not eligible; the CoverKids beneficiary dies; or for other reasons.

◆ I understand that computer crosschecking may be used to verify information I have provided on this application.

◆ I understand that I can report suspected fraud and abuse by calling toll-free 1-866-795-1977 or (615) 253-9955.

◆ I understand that I have the right to appeal an enrollment decision. I will be notified of my rights if my application is denied for any reason.

By signing, you are acknowledging that you have read and accept these statements and that the information you have supplied is correct to the best of your knowledge. Also, by signing you are granting permission to release protected health information as described below. Please read before signing.

Permission to Release Protected Health Information:

• I agree that my [and my child(ren)]'s information can be exchanged between CoverKids, Tennessee Department of Human Services, Tennessee Inspector General, TennCare and other State or Federal Agencies and their contractors. The following information can be shared:
  - Social security numbers;
  - Income information;
  - Health information; and
  - Eligibility information, which includes information about where I live, whether I have health insurance, whether the person applying for CoverKids is a U.S. citizen, and who lives in my house

• This information needs to be shared in order to check your eligibility for CoverKids and/or denial or eligibility for other State and Federal programs including TennCare, Medicaid and other Title V programs such as Children's Special Services programs.

• Additionally, this information may be used for audit purposes and the conducting of CoverKids business, which may include making payments to your healthcare provider and evaluating the performance of a health plan or healthcare provider.

• The income information provided on this application cannot be used by the Internal Revenue Service (IRS) for tax purposes.

• I agree on behalf of myself (and my child(ren), if applicable) to share the information listed above.

• I understand that I do not have to sign this form, however, if I do not sign this form or if I take back my permission, CoverKids may not be able to determine if I or my child(ren) is/are eligible and may deny my or my child(ren)'s eligibility to receive said benefits.

• I see the information on this agreement and understand that I can receive a copy of this signed agreement upon request from CoverKids' Administrative Contractor, Policy-Studies, Inc. (PSI) at 1.866.620.8864.

• I understand that this Release is valid from the date this application is signed. This authorization is valid until all family members included on this application cease participation in CoverKids.

• I understand that if the person or organization authorized to receive the information is not a health plan or a health care provider, the information released may no longer be protected by federal privacy regulations.

• I have read, or have had read to me, the above information, and understand how my protected health information is to be used. This authorization is valid until all family members included on this application cease participation in CoverKids.

1st Responsible Adult Signature _____ Date:____/____/____
(Required)

2nd Responsible Adult Signature _____ Date: ____/____/____
(*Suggested but not required.*)

Authority: Titles XIX and XXI of the Social Security Act. Completion of this form is required to enroll in a health plan.
Policy Studies, Inc. (PSI) is the Administrative Services Contractor for CoverKids,
under contract with Benefits Administration.

FOR OFFICIAL USE ONLY

Name of certified entity assisting with application: _____

Certified Entity Identification Number: _____

Contact Name: _____ Contact Telephone Number: _____

APPLICATION CHECKLIST

Before you send in, make sure you have…

- ❑ Completed **ALL** the items in Sections 1, 2, 4, 5, 6. (Section 3 should be completed **ONLY** if you are applying for pregnancy benefits for a responsible adult or pregnant child.)
- ❑ Checked yes for all children for whom you are applying.
- ❑ Supplied us with a Social Security Number for each child for whom you are applying.
- ❑ Attached copies of documents that prove children's qualified alien status if they are not U.S. citizens.
- ❑ Attached a provider's statement if you are applying for pregnancy benefits. (You or your doctor can download the statement from our website. http://www.covertn.gov/web/coverkids_app_english_provider.pdf.)
- ❑ Supplied us with all income information.
- ❑ Attached copies of federally recognized tribal papers if the child or pregnant woman is American Indian/Alaskan Native. (There are no co-pays only if these papers are received; otherwise, the low co-pays will apply.)
- ❑ Attached copies of insurance cards if you have insurance now or have had it in the last three months and also attached a copy of the confirmation letter if coverage was involuntarily lost.
- ❑ Attached a DHS denial letter (if you are being terminated or recently have been terminated from TennCare) - Send in your most recent DHS denial letter with the TennCare termination date along with the reason code.
- ❑ Attached a DHS denial letter (if applicant has been denied TennCare by DHS) - Send in your most recent DHS denial letter with the reason code.
- ❑ Signed the application.
- ❑ Made a copy for your records.

When you have filled out the application completely and signed,
send it with any required documents to:

CoverKids
P. O. Box 2010
Cleveland, TN 37320-2010


COVERKids